Summary of Benefits

This section summarizes your UMP Neighborhood benefits.

Please note that UMP Neighborhood has no waiting period for coverage of preexisting conditions.

If Medicare is your primary coverage, please refer to "UMP Neighborhood Provisions for Retirees on Medicare" starting on page 51. UMP Neighborhood care systems and restrictions outside the service area may not apply to you.

Student dependents attending school outside King, Pierce, and Snohomish counties may access all covered services, routine and emergent, from approved provider types outside the service area. After deductibles are met, benefits for care from providers outside the service area of King, Pierce, and Snohomish counties will generally be paid either at 90% of allowed charges (UMP PPO providers within Washington State, Oregon, and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce) or at 80% of allowed charges (all other providers, including providers out-of-state). Parents with student dependents expecting to get out-of-area care should call Customer Service at 1-888-380-2822 for more detailed instructions and information.

Network reimbursement level applies to:

- Covered services provided by all providers within your UMP Neighborhood care system;
- Covered services provided by UMP PPO network providers when your care system provider has notified UMP that he or she has referred you for medically necessary care not obtainable within your care system; or
- UMP PPO network provider services for which you can self-refer such as alternative care, women's health care, and behavioral health (see "Other Health Care Services" on pages 15-16 for details).

Non-network reimbursement level applies to:

- Self-referrals to Washington State providers outside your care system other than self-referrals that are permitted under this plan (see "Other Health Care Services" on pages 15-16).
- Services from providers outside your care system when UMP is not notified by your care system provider of a referral.

Out-of-network reimbursement level (80% of allowed charges) applies to:

- Care system provider referrals for medically necessary services to a provider who does not contract with the UMP PPO network; or
- Services by a non-network provider received for an urgent condition or medical emergency.

Conditions treated outside Washington State that are not considered urgent or medical emergencies are not covered.

UMP Neighborhood covers only medically necessary services and supplies, as defined on pages 73-74. Please refer to "Covered Expenses" as well as "Expenses Not Covered, Exclusions, and Limitations" for more details. For any UMP Neighborhood covered benefit, once you have met the cost-sharing requirements, UMP Neighborhood pays at the levels shown on the following summary charts, subject to any benefit maximums or limits indicated. The percent paid by UMP Neighborhood refers to percent of the allowed charge only. The remaining amount of the allowed charge is your enrollee coinsurance (defined on page 72).

Only the *allowed charge* is covered—the maximum payment UMP Neighborhood allows for a specific service or supply (see definition on page 70). In many cases, UMP Neighborhood's allowed charge is less than the provider's billed charge for the service. This means that for most non-network and out-of-network services, you will be responsible for not only the enrollee coinsurance but also the difference between the billed and allowed charges.

In most circumstances, UMP Neighborhood follows Medicare policy related to claims payment policies and procedures.

Some services also have specific limits, as shown in the summary charts.

The following sections describe your UMP Neighborhood benefits along with other details you'll need to use your coverage effectively. If you have questions, see the Directory (inside the front cover) for contact information.

Summary of Benefits

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is often less than the provider's billed charge. Note:** If Medicare is the primary payer, all services outside of Washington, Oregon, or the Idaho counties of Bonner, Kootenai, Latah, or Nez Perce, will be paid as out-of-network.

Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Acupuncture 16 treatments max/year	90%	60%	No	23, 40
Ambulance Air and ground	80%	80%	No	23, 40, 73
Biofeedback (if for mental health diagnosis, see Mental Health benefits)	90%	60%	No	23, 28
Blood and Blood Derivatives	90%	60%	No, except stem cell harvesting for transplant purposes	24, 40
Bone, Eye, and Skin Bank Services	90%	60%	No	24
Cardiac and Pulmonary Rehabilitation	90%	60%	Yes	20, 24
Chemical Dependency Treatment $12,500 maximum plan payment per consecutive 24 calendar month period for inpatient and outpatient combined (excludes detox if you haven't been admitted to a chemical dependency program when receiving those services)				24, 40, 43, 71, 76
• **Inpatient**	100% after $200 copay/day; $600 max copay/person/year	60%	No	
• **Outpatient**	90%	60%	No	
Dental Services (limited – does not include routine dental care, or most common dental services)	90%	60%	No, except surgical treatment of TMJ	24, 40
Diabetes Education	90%	60%	No	18, 25, 41

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Diagnostic Tests, Laboratory, and X-Rays (outpatient)	90%	60%	Certain services	25
Dialysis	90%	60%	No	25, 41
Durable Medical Equipment, Supplies, and Protheses ***Note:*** For a wig or hairpiece to replace hair lost due to radiation or chemotherapy, $100 lifetime max	90%	60%	Yes, for rentals over 3 months and purchases over $1,000	20, 25-26, 41, 71
Emergency Room (ER) ER copay waived if admitted directly from ER; copay does not count toward the annual medical/surgical deductible or medical/surgical out-of-pocket limit	90% after $75** copay/visit	80% after $75** copay/visit	No	19, 26, 73
Hearing Care $400 max/36 months applies to routine hearing exam, hearing aid, and rental/repair combined	90%	60%	No	26, 41
Home Health Care	90%	60%	Yes	26-27, 41, 42, 72
Hospice Care				20, 27, 41, 43, 73
• **Inpatient**				
When preauthorized	100%	60%	Yes	
When NOT preauthorized	90%	60%	No	
• **Respite Care** ($5,000 lifetime max)	100%	60%	Yes	
Hospital Services				
• **Inpatient**				20, 27,
Facility charges	100% after $200 copay/day; $600 max copay/person/year	60%	No; see "Physical, Occupational, Speech, and Massage Therapy" for exceptions.	42
Professional services	90%	60%	No	
• **Outpatient**	90%	60%	No	27, 43

(continued on next page)

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

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Summary of Benefits, continued

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is often less than the provider's billed charge. Note:** If Medicare is the primary payer, all services outside of Washington, Oregon, or the Idaho counties of Bonner, Kootenai, Latah, or Nez Perce, will be paid as out-of-network.

Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Mammograms				
• **Screening mammograms*** (beginning at age 40, every one or two years)	100%	60%	No	25, 37
• **Diagnostic mammograms**	90%	60%	No	25
Mastectomy and Related Services	90%	60%	No	27-28
Mental Health Treatment				28, 42, 43, 75
• **Inpatient:** 10 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	No, except for partial hospitalization services	
• **Outpatient:** 20 visits max/year	90%	60%	No	
Naturopathic Physician Services	90%	60%	No	28, 40, 41
Neurodevelopmental Therapy (Ages 6 years and under)				29, 30-31, 42
• **Inpatient:** 60 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	No	
• **Outpatient:** 60 visits max/year for all therapies combined	90%	60%	No, but treatment plan required	
Obstetric and Newborn Care				29
• **Inpatient**				
Facility charges	100% after $200 copay/day; $600 max copay/person/year (Routine newborn nursery care is not subject to copay)	60%	No	
Professional services	90%	60%	No	
• **Outpatient**	90%	60%	No	

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

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For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Office, Clinic, and Hospital Visits	90%	60%	No	29, 40, 42
Organ Transplants				20, 30, 42
• **Inpatient**				
Facility charges	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	
Professional services	90%	60%	Yes	
• **Outpatient** Donor search (bone marrow, stem cell, umbilical cord) is limited to 15 searches per transplant	90%	60%	Yes	
Out-of-Network Care[1] See definition on page 75.	Not applicable	80%	Varies by service/ supply	15, 42, 75
Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)	90%	60%	No	30, 43, 70
Phenylketonuria (PKU) Supplements	90%	60%	No	30, 40
Physical, Occupational, Speech, and Massage Therapy				20, 30-31, 42
• **Inpatient:** 60 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	
• **Outpatient:** 60 visits max/year	90%	60% (massage therapists not covered)	No, but treatment plan required	

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* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

[1] If Medicare is the primary payer, all services received outside of Washington, Oregon, and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce will be paid as out-of-network.

For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

Summary of Benefits, continued

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is often less than the provider's billed charge. Note:** If Medicare is the primary payer, all services outside of Washington, Oregon, or the Idaho counties of Bonner, Kootenai, Latah, or Nez Perce, will be paid as out-of-network.

Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Prescription Drugs* (up to a 90-day supply)				21-22, 31-32, 40, 41, 42, 43, 71, 72, 75
• **Retail pharmacies****: Annual prescription drug deductible applies. After you meet your annual prescription drug deductible, your cost-share limit for Tier 1 and Tier 2 drugs is: $50 per prescription for up to 30 days' supply, $100 per prescription for 31-60 days' supply, and $150 per prescription for 61-90 days' supply. Limit does not apply to Tier 3 drugs and prescriptions purchased at non-network pharmacies.				
Tier 1: Generic drugs, all insulin, and all disposable diabetic supplies	80% (enrollee coinsurance is 20% or cost share limit, whichever is less)	80%	Certain drugs	
Tier 2: Preferred brand-name drugs	70% (enrollee coinsurance is 30% or cost-share limit, whichever is less)	70%	Certain drugs	
Tier 3: Nonpreferred brand-name drugs	50%	50%	Certain drugs	
• **Mail-Service pharmacy****: Annual prescription drug deductible applies. If the actual price of the medication is less than the standard copay, you pay a minimum charge of $8.99 or the cost of the drug, whichever is greater—but not more than the standard copay.				
Tier 1: Generic drugs, all insulin, and all disposable diabetic supplies	100% after $10 copay/refill	Not covered	Certain drugs	
Tier 2: Preferred brand-name drugs	100% after $40 copay/refill	Not covered	Certain drugs	
Tier 3: Nonpreferred brand-name drugs	100% after $80 copay/refill	Not covered	Certain drugs	

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

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Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Preventive Care* See specific services covered	100%	60%	No	32-37, 40, 42
Radiation and Chemotherapy	90%	60%	No	38
Second Opinions				20, 38
• **When required by UMP***	100%	100%	No	
• **When optional**	90%	60%	No	
Skilled Nursing Facility 150 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	20, 38, 40, 42, 43, 76
Special Nursing Services $5,000 max/year	90%	60%	No	38, 43
Spinal and Extremity Manipulations 10 visits max/year	90%	60%	No	38, 42
Temporomandibular Joint (TMJ) Treatment (surgical)	90%	60%	Yes	20, 38, 40
Tobacco Cessation Program* *Free & Clear* program only	100%	Not covered	No	38-39, 43
Vision Care*				
• **Eye exams** (routine)—Once every two calendar years	90%	60%	No	39, 42
• **Vision hardware**—Including frames, lenses, contact lenses, and fitting fees combined	$100 max plan payment every two calendar years	$100 max plan payment every two calendar years	No	
Well-Baby Preventive Care Services* See specific services covered under "Preventive Care"	100%	60%	No	33-35, 40, 42

* Not subject to the annual medical/surgical deductible.

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